DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

40888

State File No.

Registration District No. 22-399 Primary Registration District No. 1602 Registrar's No. 4565

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: St Joseph Hospital
(If not in hospital or institution, write street address or location)
(d) Length of stay: In hospital or institution 3 weeks 0 (Specify whether years, months or days)
In this community 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 078
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 7005 Benton Blvd 3 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME THERESA. I. O'LEARY
3. (b) If veteran, name war NO
3. (c) Social Security No. NO
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William A. O'Leary 6. (c) Age of husband or wife if alive, if dead, how long Unk years
7. Birth date of deceased March (Month) 23 (Day) 1873 (Year)
8. AGE: Years 68 Months 8 Days 14 If less than one day hr. min.
9. Birthplace Odessa Mo. (City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business
MOTHER FATHER 12. Name Daniel Bermingham
13. Birthplace Ireland (City, town or county) (State or foreign country)
MOTHER 14. Maiden name Ann Fay
15. Birthplace Ireland (City, town or county) (State or foreign country)
16. (a) Informant William A. O'Leary
(b) Address 7005 Benton
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-41 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director J. O'Donnell
(b) Address 3236 Broadway K.C. Mo.
19. (a) 12/9/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7th
year 1941 hour minute P M.
21. I hereby certify that I attended the deceased from 11-8-41, 19..., to Dec 7 - 19 41
that I last saw h-- alive on Dec 7 - 19 41
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocardial Failure	
Due to Terminal Bronchi Pneumonia	
Due to Hypertensive Heart Disease	
Other conditions (Include pregnancy within 3 months of death) Fracture Hip 2nd	
Major findings of operations Operation Smith Peterson Nail 2nd Angle Bar	
Of autopsy No	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. B. Kelly (M. D. or other)
Address 7th & Baltimore K.C. Mo. Date signed 12-9-41

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
—2-21-40
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Registration District No.
Primary Registration District No.
Registrar's No. 4565

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Theresa O'Leary
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: 68 Years | Months | Days | If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 2/14/42 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Myocardial failure Chronic
Due to Hypertensive Heart disease
Due to Heart Failure Pneumonia
Other conditions Fractured hip
(Include pregnancy within 3 months of death)
Major findings:
Of operations 1860
Of autopsy 18

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide~~ or ~~homicide~~ (specify) 11-7-41 accident
(b) Date of occurrence 11-7-41 11 A.M.
(c) Where did injury occur? Kansas City (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Bath Room - Home 2005 Benton
(Specify type of place)
While at work? (c) Means of injury
23. Signature M. O. Hill (M. D. or other)
Address K. C. Mo. Date signed Jan 30 '42

S-40888